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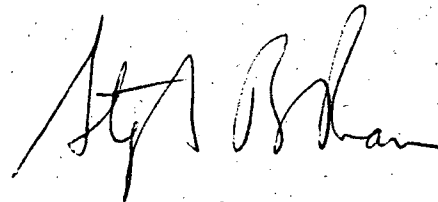
October 11, 1991

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 91-19-00

Document Control Desk
US Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

The attached Licensee Event Report LER 91-19-00 is hereby
submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,



Attachment

cc: Mr. Thomas T. Martin
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Francis J. Williams, Jr., Project Manager
Project Directorate I-1
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US Nuclear Regulatory Commission
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ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

NRC Form 366 (6-89)

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (6)

PAGE (3)

Indian Point Unit No. 2

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YEAR

SEQUENTIAL

REVISION

NUMBER

NUMBER

9 1

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0 2

OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Containment Spray Pump and Sodium Hydroxide Spray Eductor Simultaneously Inoperable

EVENT DATE:

September 11, 1991

REPORT DUE DATE:

October 11, 1991

REFERENCES:

Significant Occurrence Report (SOR) 91-453, 454, 455
Station Administrative Order No. 132 Event Report No. 91-17

PAST SIMILAR

None

DESCRIPTION OF OCCURRENCE:

On September 11, 1991, while the plant was at 100% power, a limiting condition for operation (LCO) action statement was entered for the conduct of quarterly surveillance testing of containment spray pump (CSP) No. 22. An LCO is entered for the conduct of this test since manual isolation of the pump discharge is performed to eliminate the possibility of causing the containment to be sprayed. This test was completed and the LCO was cleared. A review of the results of this test indicated that the sodium hydroxide (NaOH) additive eductor had produced 20 gpm flow which is less than the 50 gpm flow required by the test procedure. At 1140 hours, a 72 hour LCO was entered because of the inoperable NaOH additive eductor.

An engineering calculation was performed to determine if the reduced NaOH flow was acceptable. The results of this calculation showed that the reduced NaOH flow would satisfy the FSAR assumptions. The 72 hour LCO on the eductor was terminated at 1900 hours based on the engineering calculation as approved by the Station Nuclear Safety Committee (SNSC).

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION OF OCCURRENCE: (continued)

The surveillance test on CSP 22 was repeated at 2045 hours. At 2249 hours the test results indicated that spray additive flow had degraded further and was less than that required by the engineering calculation. This rendered the NaOH additive eductor inoperable. Therefore, Technical Specification 3.0.1 was entered at 2249 hours since CSP 22 was still in the test line-up (pump discharge manually isolated). At 2307 hours, the line-up of CSP 22 was restored and the plant exited the provision of Technical Specification 3.0.1, after being under that provision for 18 minutes.

On September 12, 1991 with a 72 hour LCO in effect because of the inoperable NaOH additive eductor, a repair of a manual valve on the suction side of the eductor was being conducted. At 1312 hours the repair was completed and Technical Specification 3.0.1 was entered to line-up CSP 22 for testing. At 1326 hours the surveillance test on CSP 22 was completed indicating that spray additive flow was 60 gpm. At that time the plant exited the provision of Technical Specification 3.0.1, after being under that provision for 14 minutes.

The operability of CSP 21 and its associated spray additive eductor had been demonstrated operable both before and after the event described above.

ANALYSIS OF OCCURRENCE:

Technical Specification 3.0.1 applies when plant conditions exceed the conditions permitted by the Technical Specifications. Consequently, two entries into Technical Specification 3.0.1 occurred and are reportable under 50.73(a)(2)(i)(B).

During the periods of time when the above LCO action statements and Technical Specification 3.0.1 were entered, other components associated with containment cooling and Iodine removal were fully operable. These components included five fan cooler units and one containment spray pump with its associated NaOH spray additive eductor.

CAUSE OF OCCURRENCE:

The surveillance tests on CSP 22 demonstrated that the NaOH spray flow for CSP 22 was being restricted. An investigation determined that the most probable cause was associated with a manual valve in the suction side of the NaOH additive eductor. The repair team found that the diaphragm had separated from the stem. In this configuration flow through the valve would be restricted. The failure of this valve is attributed to the incorrect configuration of the finger plate in a bonnet assembly that was installed on the valve during the 1991 refueling outage. It is believed that this bonnet assembly was received from the vendor in this condition. It has been demonstrated that if the valve were opened in this incorrect configuration the diaphragm would separate from the stem.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

CORRECTIVE ACTION:

The manual valve in the NaOH spray line was repaired, tested and determined to be operable. Training for operations personnel on the operation of this type of valve was conducted by the Watch Engineers.

Another diaphragm valve that had been worked on during the 1991 refueling outage is located in the common spray header to both containment spray pumpeductors. A radiograph of this valve was performed to determine the configuration of the plate. It was found to be configured correctly.

A review is being conducted to determine if there are any of the same type of valves installed in other safety related applications that could have an incorrectly installed finger plate.

The maintenance procedure for these types of valves is being revised to describe the correct configuration of the finger plate. A training module on how to correctly install the finger plate in these valves will be presented in the maintenance training cycle scheduled to begin in the fourth quarter of 1991.